Fishtoft Academy

Intimate Care Policy

Principles

1.0 The Governing Body will act in accordance with Section 175 of the Education Act 2002 and 'Safeguarding Children and Safer Recruitment in Education' (DCSF 2006) to safeguard and promote the welfare of students and pupils at the federation academies.

1.1 The Governing Body and Chief Executive Officer will act in accordance with the supplementary DCSF guidance: 'Safer Recruitment and Selection in Education Settings' (2005) and 'Dealing with Allegations of Abuse against Teachers and other Staff' (2005)

1.2 This federation takes seriously its responsibility to safeguard and promote the welfare of the children and young people in its care. Meeting a child's intimate care needs is one aspect of safeguarding.

1.3 The Governing Body recognises its duties and responsibilities in relation to the Disability Discrimination Act which requires that any child with an impairment that affects his/her ability to carry out day-to-day activities must not be discriminated against.

1.4 This intimate care policy should be read in conjunction with the following

- Safeguarding Policy
- Health and safety policy and procedures
- The administration of medicines section of the First Aid Policy
- Special Educational Needs policy
- Physical Intervention Policy
- Staff code of conduct or guidance on safe working practice.

1.5 The Boston Witham Academies Federation is committed to ensuring that all staff responsible for the intimate care of children will undertake their duties in a professional manner at all times. It is acknowledged that these adults are in a position of great trust.

1.6 The academy recognises that there is a need to treat all children, whatever their age, gender, disability, religion or ethnicity, with respect when intimate care is given. The child's welfare and dignity is of paramount importance. No child should be attended to in a way that causes distress or pain.

1.7 Staff will work in close partnership with parent/carers to share information and provide continuity of care.

Definition

2.0 Intimate care can be defined as any care which involves washing, touching or carrying out a procedure to intimate personal areas which most people usually carry out themselves but some children are unable to do because of their young age, physical difficulties or other special needs. Examples include care associated with continence and menstrual management as well as more ordinary tasks such as help with washing, toileting or dressing.

2.1 It also includes supervision of children involved in intimate self-care.

Best Practice

3.0 Staff who may need to provide intimate care at each academy will be trained to do so including child protection and health and safety training in moving and handling (which can be provided by the appropriate LA officers/advisers) and are fully aware of best practice regarding infection control, including the need to wear disposable gloves and aprons where appropriate.

3.1 Staff will be supported to adapt their practice in relation to the needs of individual children taking into account developmental changes such as the onset of puberty and menstruation.

3.2 As an additional safeguard, staff involved in meeting intimate care needs will not usually be involved with the delivery of sex education to the same children, wherever possible.

3.3 There is careful communication with each child who needs help with intimate care in line with their preferred means of communication (verbal, symbolic, etc.) to discuss their needs and preferences. Where the child is of an appropriate age and level of understanding permission should be sought before starting an intimate procedure.

3.4 All children will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will encourage each child to do as much for his/herself as possible.

3.5 Children who require regular assistance with intimate care have written Pupil Passports (PP) or care plans agreed by staff, parents/carers and any other professionals actively involved, such as school nurses or physiotherapists. These plans include a full risk assessment to address issues such as moving and handling, personal safety of the child and the carer. Any historical concerns (such as past abuse) should be noted and taken into account. (NB More information regarding care plans and risk assessments for children with complex medical needs can be found in 'Including Me: Managing Complex Health Needs in Schools and Early Settings' by Jeanne Carlin, published by the Council for Disabled Children and DCFS, 2005)

3.6 Where a care plan or PP is not in place, parents/carers will be informed the same day if their child has needed help with meeting intimate care needs (e.g.: has had an 'accident' and soiled him/herself). It is recommended practice that information on intimate care should be treated as confidential and communicated in person, by telephone or by sealed letter, not through the home/academy diary/planner.

3.7 Every child's right to privacy will be respected. Careful consideration will be given to each child's situation to determine how many carers might need to be present when a child needs help with intimate care. Where possible there should be 2 people present. Adults who assist children one-to-one should be employees of the academy and be CRB checked at the appropriate level.

3.8 It is not always practical for two members of staff to assist with an intimate procedure and also this does not take account of the child's privacy. It is advisable, however, for a member of staff to inform another adult when they are going to assist a child with intimate care.

3.9 Wherever possible the same child will not be cared for by the same adult on a regular basis; there will be a rota of carers known to the child who will take turns in providing care. This will ensure, as far as possible, that over-familiar relationships are discouraged from developing, while at the same time guarding against the care being carried out by a succession of completely different carers.

3.10 Wherever possible staff should care for a child of the same gender. However, in some circumstances this principle may need to be waived; for example, female staff supporting boys in a primary school as no male staff are available. Male members of staff should not normally provide routine intimate care (such as toileting, changing or bathing) for adolescent girls. This is safe working practice to protect children and to protect staff from allegations of abuse.

3.11 The religious views and cultural values of families should be taken into account, particularly as they might affect certain practices or determine the gender of the carer.

3.12 All staff should be aware of the academy's confidentiality policy. Sensitive information will be shared only with those who need to know.

3.13 If necessary, advice should be taken from the local council regarding disposal of large amounts of waste products.

Child Protection

4.0 The Governors and staff at each academy recognise that children with special needs and disabilities are particularly vulnerable to all types of abuse.

4.1 The academy's safeguarding policy and inter-agency child protection procedures will be accessible to staff and adhered to.

4.2 From a child protection perspective it is acknowledged that intimate care involves risks for children and adults as it may involve staff touching private parts of a child's body. It may be unrealistic to expect to eliminate these risks completely, but across the federation best practice will be promoted and all adults will be encouraged to be vigilant at all times.

4.3 Where appropriate, all children will be taught personal safety skills carefully matched to their level of development and understanding.

4.4 If a member of staff has any concerns about physical changes in a child's presentation, e.g. unexplained marks, bruises, soreness etc s/he will immediately report concerns to the Head of Academy. A clear written record of the concern will be completed and a referral made to Children's Services Social Care if necessary, in accordance with inter-agency procedures. Parents will be asked for their consent or informed that a referral is necessary prior to it being made unless it is considered that to do so will place the child at risk of harm.

4.5 If a child becomes distressed or very unhappy about being cared for by a particular member of staff, this should be reported to the Head of Academy or Chief Executive Officer. The matter will be investigated at an appropriate level (usually the Chief Executive Officer) and outcomes recorded. Parents/carers will be contacted at the earliest opportunity as part of this process in order to reach a resolution. Staffing schedules will be altered until the issue(s) are resolved so that the child's needs remain paramount. Further advice will be taken from outside agencies if necessary.

4.6 If a child makes an allegation against an adult working at the academy, this will be investigated by the Chief Executive Officer (or by the Chair of Governors if the concern is about the Chief Executive Officer) in accordance with the agreed procedures.

4.7 Any adult who has concerns about the conduct of a colleague at the academy or about any improper practice will report this to the Chief Executive Officer or to the relevant Chair of Governors, if the concern is about the Chief Executive Officer.

Physiotherapy

5.0 Children who require physiotherapy should have this carried out by a trained physiotherapist. If it is agreed in the PP or care plan that a member of staff should undertake part of the physiotherapy regime (such as assisting children with exercises), then the required technique must be demonstrated by the physiotherapist personally, written guidance given and updated regularly.

5.1 Under no circumstances should staff devise and carry out their own exercises or physiotherapy programmes.

5.2 Adults (other than the physiotherapist) carrying out physiotherapy exercises with children should be employees of the academy.

5.3 Any concerns about the regime or any failure in equipment should be reported to the physiotherapist.

Medical Procedures

6.0 Children with disabilities might require assistance with invasive or non-invasive medical procedures such as the administration of rectal medication, managing catheters or colostomy bags, adrenalin injections. These procedures will be discussed with parents/carers, documented in the PP or care plan and will only be carried out by staff who have been trained to do so.

6.1 Any members of staff who administer first aid should be appropriately trained. If an examination of a child is required in an emergency aid situation it is advisable to have another adult present, with due regard to the child's privacy and dignity.

Record Keeping

8.0 It is good practice for a written record to be kept in an agreed format every time a child has physiotherapy or requires assistance with intimate care, including date, times and any comments such as changes in the child's behaviour. It should be clear who was present.

8.1 These records will be kept in the child's file and available to parents/carers on request.

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